

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

AUG 18 1934

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Do not use this space.

1. PLACE OF DEATH

County *St. Louis*
 Township *Carondelet*
 City *St. Louis* (No. *1120*)

Registration District No. *1120*Primary Registration District No. *1120*File No. *27755*Registered No. *260*St. *St. Louis* Ward *11*

2. FULL NAME

(a) Residence, No. *400 E. Rapa*
 (Usual place of abode)

St. *St. Louis* Ward *11*

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. *4* mos. *0* ds. How long in U. S., if of foreign birth? yrs. *0* mos. *0* ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Single*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *—*6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *July 13, 1913*

7. AGE YEARS *21* MONTHS *0* DAYS *7* IF LESS than 1 day, *—* hrs. *—* or *—* min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *Teacher*

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. *Academy*

10. Date deceased last worked at this occupation (month and year) *—* 11. Total time (years) spent in this occupation *—*

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Fort Madison Iowa*13. NAME *Frank Freitag*14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Fort Madison Iowa*15. MAIDEN NAME *Helen Witte*16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Fort Madison Iowa*17. INFORMANT (ADDRESS) *Sister Fredericka 400 E. Rapa*18. BURIAL, CREMATION, OR REMOVAL PLACE *St. Louis* DATE *July 23, 1934*19. UNDERTAKER (ADDRESS) *C. Hoffmann 1678 E. Broadway*20. FILED *7-23* 1934 *D. F. Yates M.D.* Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *July 20, 1934*22. I HEREBY CERTIFY, That I attended deceased from *July 20th 1934* to *July 20th 1934*I last saw her alive on *July 20th 1934* Death is saidto have occurred on the date stated above, at *8:30 A.M.*

The principal cause of death and related causes of importance were as follows:

Acute Myocarditis Date of onset *July 18-34**Insolation* *7-20-34*Other contributory causes of importance *—*Name of operation *—* Date of *—*What test confirmed diagnosis? *—* Was there an autopsy? *no*

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? *—* Date of injury *—*, 19*—*Where did injury occur? *—* (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury *—*Nature of injury *—*24. Was disease or injury in any way related to occupation of deceased? *no*If so, specify *—*(Signed) *Joseph Hardy* M. D.(Address) *7602 S. Broadway - St. Louis*

